| DEPAR | RTMENT OF HEALTH | AND HUMAN SERVICES | ٠. م . ١ | | PRINTER | 06/03/201: |
|-------------------|--|---|----------------------------|---|----------------|----------------------------|
| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | 45 | - 7/11/1/2 | FORM | 1 APPROVEI |
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | PLE CONSTRUCTION / | (X3) DA | . 0938-039 E SURVEY |
| <u>L</u> | | 44E200 | B. WING | | 1 | |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | | | 05 | 30/2013 |
| LAUREL | BROOK SANITARIUM | • | Si | REET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE | | |
| | | | | DAYTON, TN 37321 | | |
| (X4) ID PREFIX | SUMMARY STAT | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID. | PROVIDER'S PLAN OF CORRECT | | |
| TAG | REGULATORY OR LE | SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | IDEC | (X5) COMPLETION DATE |
| F 170 | 483.10(i)(1) RIGHT | TO PRIVACY | | F 170 492 10(2)(1) PVC | | |
| SS≃D | SEND/RECEIVE UN | NOPENED MAII | F 170 | F 170 483.10(i)(1) RIGHT TO | 0 | 6/11/13 |
| _ | | | | PRIVACY-SEND/RECEIVE |] | |
| | The resident has the | right to privacy in written | | UNOPENED MAIL | | |
| | communications, inc | Studing the right to send and | | The resident has the right to pr | ivacy in | |
| | promptly receive ma | il that is unopened. | | written communications, inclu | ding the | |
| į | | | | right to send and promptly rece | ive | |
| J | | · | | mail that is unopened | | |
| | by: | T is not met as evidenced | | Resident #8 | ļ | |
| } | cased on medical re | ecord review, facility policy | | 45 | | |
| | the resident's rights of | the facility failed to ensure of privacy by opening mail of | - | On 5/30/13 the Administration | trator | |
| | one resident, #8, of t | Wenty-four residents | } | communicated to all nur | sing | |
| | reviewed. | | | staff (RN, LPN, CNA), | Social | |
|) | | | | Services, Activities. | i | |
| | The findings included | f : | ٠ | Restorative, and Busines | ss | j |
| | Medical report review | | | Office that Resident #8 | loes | - 1 |
| - 1 | vata Set (MDS), date | v of the quarterly Minimum ad March 28, 2013, revealed Mental Status (BIMS) score | | not want her mail opene | d. | |
| 10 | of 15 (15 equals cong | gitively intact). | | On 5/30/13 the Adminis | trator | } |
| | | · | | reviewed & revised the p | nolicy | |
| | Review of the facility | policy "Resident Rights" |] | for identifying residents | 70205 | [|
| 1 [| evealedlaws guar | antee certain basic rights to cilityinclude the resident's | : | request for handling their | r mail_ | |
| | ight to:h. Privacy in | sending and receiving | l _l | the Admission Resident | 1220011 | |
| r | nail" | seriding and receiving | | Agreement and Resident | | i |
| 1 | | 1 | | Rights. (Exhibit # | | } |
| 1 | nterview with residen | t #8, on May 30, 2013, at | ľ | (EXIIIOIT # | ² / | i |
| | IO:30 a.m., in the resi | dent room, revealed " |]. | On 6/10/13 & 6/11/13 the Di | roof | [|
|] [| Social Worker) opens | s the mail, I never get |] 1 | of Nursing (DON) conducted | rector | |
| 6 | anyumiy mat (SI) t ope sends me money and | ned, my son in Oklahoma (Social Worker) always | ì | mandatory in-service for all | ıa | |
| ه ا | poens it and looks to | see if he sent me money" | ļ | nursing staff (RN, LPN, CNA | | } |
| | | - | ĺ | Dietary Rusings are | 1), | |
| ļ is | nterview with the Soc | ial Worker in the | | Dietary, Business office, Soc | iai | |
| 6 | Restorative room, on I | May 30, 2013, at 10:45 | İ | Services, Activities, Restorat | ive, | - 1 |
| ODATORY | IDEATABLE AS BOOKES | (5.11- | | Housekeeping, Laundry, and | |] |
| DIACONTO | TO STATE | SUPPLIER REPRESENTATIVE'S SIGNAT | URE | TITLE | (X6 |) DATE |
| | Reit W | ul— | | Admin's tato | • | 10/12 |

afficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days oliowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4XKZ11

Facility ID: TN7201

| PLAN (| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | ULTIPLE CONSTRUCTION DING | (X3) DA |). 0938-03 TE SURVEY MPLETED |
|-------------|---|---|--------------------|---|------------------|------------------------------------|
| ., | | 44E200 | B. WIN | S | | |
| | rovider or supplier BROOK SANITARIUM | <u> </u> | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE | | /30/2013 |
| (4) ID | SUMMARYSTA | TEMENT OF DEFICIENCIES | | DAYTON, TN 37321 | · ,, | |
| EFIX FAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | V# P. P.C | (X5) COMPLETIO DATE |
| . | • | | | Therapy concerning openin and resident rights. | g mail | |
| | | | | (Exhibit | #1) | |
| | | | ,,, | Any staff not attending man | datory | |
| · [| | | 1 | in-services will not be allow | red to | |
| | | • | <u> </u> | work until they have attended in-service. | ed the | |
| | • | | · | 2) On 6/3/13 & 6/4/13 the | Social | |
| 1 | | • | | Service Director conduc | ted a | • |
| ŀ | | • | | survey with residents or | ļ | • |
| ĺ | | | l t | resident's POA to identify | fy who | |
| ĺ | | | f | wants their mail opened | or not | |
| | | • | | opened. The survey que- were the same questions | stions | |
| | | | | on the Admission Reside | usea | |
| ! | | | | Agreement form. (Exhib | | |
| - } | | | | Upon completion of surv | ev the | |
| } | • | | | results were placed on th | e | |
| | | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | | resident's care plan & | - 1 | |
| | | 940, 144 144 | - | communicated to all staff | at the | |
| - | | | | mandatory in-services | | .: |
| | | <u>.</u> | | conducted on 6/10/12 & 6/11/13 by the DON. | 1 | : |
| | · | | | 3) To ensure the deficient | | |
| } | | | | practice does not recur, the | ie l | |
| 1 | • | | | revised Resident Admissi | on | |
| - | | Ł | | Agreement will be used for | or all | |
|] | | . 1 | | new admissions to the fac | ility | |
| ļ | | Ĵ | | beginning 6/3/13 for corre | ect [.] | |
| | | ł | | documentation of handlin | g | |

| PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | MB NO. 0938-03 (X3) DATE SURVEY |
|------------------------------|--|---------------------|---|------------------------------------|
| | 44E200 | A. BUILDII | WG | COMPLETED |
| IAME OF PROVIDER OR SUPPLIER | 1 446200 | B. WING_ | | 05/30/2013 |
| AURELBROOK SANITARIUM | A | S | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 | |
| PREFIX (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION | BE COMPLETIC ATE DATE |
| | | | resident mail. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and disciplinary action imposed. Beginning 6/10/13 the Social Service Director will maintain a list of residents who want assistance and those who do not want assistance or those with special requests. The list will be maintained by the Social Services Director who will be responsible for any changes to the list. This process will continue indefinitely. 4) Beginning 6/14/13 the administrator will monitor for 3 months & then quarterly for 12 months for proper handling of resident mail by staff. These findings will be reported at the next quarterly QAPI committee meeting scheduled for July 8, 2013. The administrator will report to the Governing Body concerning these monitoring outcomes at the next Governing Body meeting. | 5 |

| DEPA | RTMENT OF HEALTH | AND HUMAN SERVICES | | | PRI | NTEC | : 08/03/201 | 13 |
|--------------------------|--|--|-------------------|-----------------|---|---------|------------------------------------|------------|
| STATEME | ERS FOR MEDICARE NT OF DEFICIENCIES | & MEDICAID SERVICES | | | | -UKW | APPROVE . 0938-039 | D |
| AND PLAN | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | JI E CONICTOLICTION | (3) DAT | : 0930-039 'E SURVEY MPLETED | <u>'''</u> |
| | | 44E200 | B. WING | s | | | | |
| NAME OF | PROVIDER OR SUPPLIER | | <u></u> | J _{or} | | 05/ | 30/2013 | |
| LAURE | LBROOK SANITARIUM | | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTINUE INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | TE. | (XS) COMPLETION DATE | - |
| | Continued From paga.m., confirmed the that are not physical mentally able to oper (explanation of bene affect" that needs to file. Interview with the Adat 12:45 p.m., in the is to be delivered to the 483.20(d)(3), 483.10 PARTICIPATE PLAN. The resident has the incompetent or other incapacitated under the participate in planning changes in care and the comprehensive care within 7 days after the comprehensive assessinterdisciplinary team, physician, a registere for the resident, and of disciplines as determined, to the extent practice and, to the extent practice and representative; as the resident, the resident participal representative; as the comprehensive as the resident, the resident practice and the resident, the resident practice and the resident, the resident practice and the resid | mail is opened for residents by able to open mail, not n mail and if it is an "EOB fits), or something to that be placed in the resident ministrator on May 30, 2013, hallway, confirmed the mail he residents unopened. (k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment. | | 80 | DEFICIENCY | ges | G/11/13 | |
| | by . | is not met as evidenced cord review and interview, | | | On 6/7/13 the DON in-service the nursing charge nurses & supervisors concerning their responsibility for ensuring care plans have the current fall interventions. | | | |

| DEPAR | RTMENT OF HEALTH | AND HUMAN SERVICES | | | . Р | RINTEC | D: 06/03/201 |
|---------------|---|---|--------------------|----------------|---|----------------|----------------------------|
| GTATCHE | ENS FOR MEDICARE | & MEDICAID SERVICES | | | | MRORI NA AN | APPROVED 0. 0938-039 |
| AND PLAN | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MA A. BUIL | JLTIPL DING | E CONSTRUCTION | (X3) DA1 | TE SURVEY MPLETED |
| <u> </u> | | 44E200 | B. WIN | G | | | |
| NAME OF | PROVIDER OR SUPPLIER | | · | T | | 05 | /30/2013 |
| LAURE | LBROOK SANITARIUM | 1 | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE AYTON, TN 37321 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | JD. | | | | |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | PREF | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | (X5) COMPLETION DATE |
| F 280 | Continued From pag | de 2 | | 200 | | | ļ <u>-</u> |
| | the facility failed to | | [F | 280 | On 6/10/13 & 6/11/13 the | | ļ |
| | comprehensive care | plan falls for one resident | | - 1 | Director of Nursing (DON) | 1 | |
| | (#25) of twenty-four | residents reviewed | [|] | conducted a mandatory in- | , | [|
| | Į | | | | service for all nursing staff | , | |
| | The finding included | : | | | (RN, LPN, CNA) | į | |
| | Resident # 25 was a | dmitted to the facility on | | | concerning communication | | |
| i | January 30, 2012, w | ith diagnoses of Anemia | | | care plan changes. (Exhibit | U1 1 | |
| | Hypertension, End S | tage Renal Disease | | | ente plan enanges. (Exmon | # 1) | j |
| | Cerebrovascular Acc | cident, Anxiety, and | | - } | Any stoff not offer 1: | ł | i |
| | Depression. | • | | | Any staff not attending | | ļ |
| ĺ | Medical record review | w revealed the resident had | | | mandatory in-services will i | not | .] |
| } | falls on: August 17, 2 | 2012, August 27, 2012, | | | be allowed to work until the | э у | i |
| | September 7, 2012, 1 | November 10, 2012 | | ĺ | have attended the in-service | ፡ | ļ |
| : [| November 27, 2012, | December 23, 2012, and | | | 0) 0 6/6/40 0 6/6/40 | | [|
| · í | May 1, 2013, with into | Bryentions of " encourage ! | | ł | 2) On 6/5/13 & 6/6/13 the DO | N | ļ |
| ļ | the resident to call for | Fassistance when in | | | & MDS nurse reviewed the | | - 1 |
| | hathroom offer mode | safety observation, assist to | | - | care plans of those residents | ; | ĺ |
| | free of clutter/obstruc | s, staff education, keep room tions daily, increase level of | | | who had fall over the past 6 | | |
| | observation chair ala | irm, bed alarm, staff in | | | months to ensure the | | l |
| | service on placement | Of Chair alarm, patient | | | interventions were listed on | the | |
| | placed in rehab progr | am. Specify | | i | care plans. There were no | - 1 | |
| i i | typeRestorative, sta | off member to always nuch | | | other residents found with fa | all | |
| | wheelchair or Geri ch | air, when taking to bus" | | ı | intervention not on care plan | | - |
| | Medical record review | rof the position of | | | · (Exhibit # 7) | | 1 |
| 1 | Medicai Teculu review Comprehensiva Casa | Plan for falls, reviewed on | | 1 | (| | |
| 1, | January 30, 2013, rev | realed no documentation for | | | | 1 | i |
| 1 | the above listed fall in | terventions from August 17, | | | | | ł |
| | 2012, through May 1, | 2013. | | İ | | | |
| 1 | nterview with care pla | an coordinator Licensed | | | | | - |
| [] | Practical Nurse (LPN) | #2, on May 30, 2013 at | | İ | | 1 | |
| [1 | 10:30 a.m., on the bad | ck terrace gazebo. | | - | | İ | } |
| 1. | writimed the care pla | an for falls had not been | | | | | |
| J. | haaren mitti (UG IU(61) | ventions initiated after the | | | | [| İ |
| | 200 001 D | | , | | | - 1 | j |

| TATEMENT OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ATIPLE CONSTRUCTION | OMB N | M APPROV O. 0938-03 |
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| PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | DING | (X3) D/ | ATE SURVEY OMPLETED |
| | 44E200 | B. WIN |) | | |
| IAME OF PROVIDER OR SUPPLIER LAURELBROOK SANITARIUN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE | 0: | 5/30/2013 |
| | | | DAYTON, TN 37321 | | |
| PREFIX EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | ~ | COMPLETION DATE |
| | | | 3) Beginning 6/3/13, the D will be responsible for investigating all inciden | ts | |
| | | Ī | including falls and writi- interventions on the Pos Investigation form. A co | t Fall | |
| - | | | the Investigation form w provided to the MDS nu put on the resident's care | rse to e plan | |
| · . | | ĭ | and communicated to the nursing staff within 24 h To ensure the deficient p does not recur, the DON supervisor will monitor of | ours. ractice or | |
| | - | | plans with fall intervention of months until substantic compliance has been obtained. | ons for | |
| | | - | 4) Beginning 6/13/13, the will report monitoring outcomes monthly to the Administrator until | e | · |
| | : : : : : : : : : : : : : : : : : : | | compliance is reached, a report outcomes quarter QAPI Committee. The QAPI meeting is schedu for blue 2 2012. The | ly to | |
| | - | | for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting | ľ | |
| | - <u>}</u> | | | | |

| DEPAR CENTE | RTMENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | İ | FORM | : 06/03/20 I APPROVE | ĒΒ |
|--------------------------|--|--|--------------------|---------------|---|-----------------------|-----------------------------------|-----------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | ILTIP DING | TERRITONATION | X3) DAT | . 0938-039 E SURVEY MPLETED | <u>91</u> |
| | | 44E200 | B. WING | 3 | | | | ı |
| NAME OF | PROVIDER OR SUPPLIER | | | STI | REET ADDRESS, CITY, STATE, ZIP CODE | 05/ | 30/2013 | _ |
| LAUREL | BROOK SANITARIUM | | | ļ 1 | 114 CAMPUS DRIVE DAYTON, TN 37321 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREF TAG | bx | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E NTE | (X5) COMPLETION DATE | N |
| F 312 | DEPENDENT RESIL A resident who is unadaily living receives t | ARE PROVIDED FOR | | 280 | PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry of activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal a oral hygiene. | out ne d and | 6/11/13 | |
| | by: Based on medical re and interview the fact dependent resident's | food (resident #3) was al of twenty-four residents | | | Upon be made aware of deficient practice on 5/29/13, the LPN charge nurse immediately removed food particle from resident # 3's mouth and provided oral hygiene. | e l the | | |
| | Resident #3 was adm October 22, 2010, wit Severe Schizophrenia Disorder, Diabetes Mand Vomiting, and Per Medical record review data set dated May 2, assistance with eating Observation on May 2 evealed resident asle with visible food on the Continued observation parts had been remove | itted to the facility on h diagnoses including l, Psychosis, Seizure ellitus, History of Nausea g tube placement. of a quarterly minimum 2013, revealed extensive required. 9, 2013, at 8:50 a.m., ep in bed with mouth open | | | On 6/4/13 the DON conducted one on one in-service with the staff feeding resident #3 concerning checking resident mouth for retained food after feeding their meals. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory inservice for all nursing staff (RN, LPN, CNA) concerning checking resident's mouth for retained food after feeding. (Exhibit #8) | ne et's r | | |

| DEPAR | TMENT OF HEALTH | AND HUMAN SERVICES | | | PRINTE | D: 06/03/201 |
|---------------|---------------------------------------|--|--------------------|--|---|----------------------------|
| | RS FOR MEDICARE TOF DEFICIENCIES | & MEDICAID SERVICES | | | FOR | MAPPROVE 0.0938-039 |
| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | ULTIPLE CONSTRUCTION LDING | (X3) D. | ATE SURVEY OMPLETED |
| | | 44E200 | B. WIN | G | | |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 0: | 5/30/2013 |
| LAUREL | BROOK SANITARIUM | | | 114 CAMPUS DRIVE | | |
| (X4) ID | SUMMARY STAT | EMENT OF DEFICIENCIES | | DAYTON, TN 37321 | · | |
| PREFIX TAG | (EACH DEFICIENCY) | MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREF TAG | EACH CORRECTIVE ACTION CH | OIH 60 555 | (%5) COMPLETION CATE |
| | | | | Any staff not attending mandatory in-services be allowed to work unhave attended the in-service be allowed to work unhave attended the in-service all residents who were dependent on being feronsure residents had swallowed all their forwas done until 6/11/13 3) Beginning 6/13/13 the &/or supervisor will cleated dependent residents at meal per week to ensure residents are swallowing food. If a resident is forwith food in their mouth assigned CNA or feeding will be disciplined immand re in-serviced. | g s will not ntil they cervice. DON ced d to d. This cek all least 1 re ig their und h, the ng tech ediately | |
| | | - 1 | | | | |
| 4 CMS-2567(0) | 2-99) Previous Versions Obsc | lete Event ID: 4XKZ11 | F | actity ID: TN7201 If continu | ation sheet P | |

| " 'D PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: | (X2) MU A. BUIL | ULTIPLE CONSTRUCTION DING | OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|--------------------|--|--|
| | | 44E200 | B. WING | S | |
| LAURELE | ROVIDER OR SUPPLIER BROOK SANITARIUM | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 | 05/30/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | HDD= consistent |
| | | | | 4) Beginning 6/13/13, the will report monitoring outcomes monthly to Administrator until compliance is reached report outcomes quarte QAPI Committee. The QAPI meeting is scheen for July 8, 2013. The Administrator will repoutcomes at the next Governing Body meeting | the , and erly to e next fuled ort |
| | | | | | |
| | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/03/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 44E200 B. WING 05/30/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 312 | Continued From page 4 F 314 483.25(c) F 312 interview and observation on May 29, 2013, at TREATMENT/SVCS TO 8:53 a.m., with Licensed Practical Nurse (LPN) PREVENT/HEAL PRESSURE #3 confirmed the staff had failed to ensure the SORES resident had swallowed all the food. F 314 483.25(c) TREATMENT/SVCS TO F 314 Resident #43 SS=D PREVENT/HEAL PRESSURE SORES 6/11/13 Based on the comprehensive assessment of a 1) On 6/3/13 the DON resident, the facility must ensure that a resident conducted a one on one inwho enters the facility without pressure sores service with the nurses who does not develop pressure sores unless the individual's clinical condition demonstrates that assessed the wound on they were unavoidable; and a resident having 1/17/13 and the nurse who: pressure sores receives necessary treatment and wrote the order on 1/19/13 services to promote healing, prevent infection and but failed to transcribe prevent new sores from developing. orders to the MAR resulting in failure of medications not This REQUIREMENT is not met as evidenced being given. (Exhibit #9) Based on medical record review, and interview. On 6/7/13 the DON reviewed the facility failed to provide care by not and revised the Current administering vitamins and minerals to promote Wound Care Protocol that the healing of a pressure sore for one (#43) resident with a stage II pressure ulcer of eliminates lab and twenty-four residents reviewed. medications at any wound stage. The change provides The findings included: the MD to order labs or Resident #43 was admitted to the facility on medications when he is January 9, 2013, with diagnoses including notified of changes in the Dementia, Diabetes, Failure To Thrive-Adult, and wound. (Exhibit #10) Hypertension. The resident expired at the facility on February 7, 2013. On 6/3/13, the DON reviewed the 24 hrs chart check policy Medical record review of the Wound Assessment Worksheet dated January 17, 2013, revealed and will continue with the 24 "...both side of coccyx...stage II Length 1 cm hour chart check

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LTIPLE CONSTRUCTION DING | (X3), DA | M APPRO D. 0938-0 ATE SURVEY OMPLETED |
|---------------------------------------|----------------------------------|---|--------------|---|---------------------------------------|--|
| | | 44E200 | B. WING | | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | <u>//30/2013</u> |
| AURELE | BROOK SANITARIUN | N . |] | 114 CAMPUS DRIVE DAYTON, TN 37321 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | | |
| PRÉFIX TAG | REGULATORY OR L | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFD TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SECTION | COMPLETO DATE |
| | | | | implemented 3/19/13 for | · · · · · · · · · · · · · · · · · · · | - |
| | | | 1 | checking all charts for wr | itten | } |
|) | | | | orders in the past 24 hour. | ς. | ļ |
| | | | 1 | This policy and process w | rill he | ļ |
| | | | | re-reviewed with the nurs | ino | ļ |
| ∬ | | | 1 | staff (RN and LPN) on 6/ | 10/13 | ļ |
| | | | } | & 6/11/13 by the DON. | | |
| i | | | | (Exhibit #1 | 1) | |
| ļ | | • | ļ | On 6/3/13 the DOM | _ | |
| ! | | • |] | On 6/3/13, the DON revie & decided to continue the | wed | • |
| ļ. | | | ĺ | process for a second nurse | | |
| , | | | | check on written physician | | |
| 1 | | • | Į. | orders that was implement | 94 | |
| J | | | | 3/19/13. The second nurse | u uzili | |
| ļ | | | | check the first nurse's wo | rk | |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | · | | on the written order to ens | nre | |
| Ť | | . † | | order was written accuratel | v i | |
| | * | | | and transcribed correctly to | . [| |
| [| | | | MAR, requisition complete | -d | |
| | • | | | lax to pharmacy, etc. Thi | s | |
| | • | | | policy and process will be | re- | |
| | | | | reviewed with the nursing s | taff | ٠ |
| - 1 | | | | (RN and LPN) on 6/10/13 & | ž | - |
| } | | | | 6/11/13 by the DON. | | |
| | | İ | | On 6/10/13 & 6/11/13 the | | |
| | | | | Director of Nursing (DON) |] | |
|] | • | j | • | conducted a mandatory in- | | |
| | | J | | service for all nursing staff |] | |
| J | | · # | 1 | (RN, LPN, CNA) concerning | e | |
| 1 | • | ` & | | transcribing physician order | | |
| 1 | | į. | | 24 hour Chart Check, Second | <i>a</i> ' | I |

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | | PRINTE | D: 06/03/2013 |
|----------------|---------------------------------|--|---------------------|---------------|---|--------------|--|
| "ATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MR. A. BUIL | ILTIPLE CO | DNSTRUCTION | OMB No | M APPROVED O. 0938-0391 ATE SURVEY DMPLETED |
| | | 44E200 | B. WING | | | | |
| NAME OF PE | ROVIDER OR SUPPLIER | | | | ADDRESS CITY CT | <u> 0:</u> | 5/30/2013 |
| LAURELB | ROOK SANITARIUM | | | 114 C | ADDRESS, CITY, STATE, ZIP CODE AMPUS DRIVE | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | | DAYT | ON, TN 37321 | | |
| PRÉFIX - | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | PREF TAG | 1 | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | 6 bc | COMPLETION DATE |
| | | | | | nurse check on physicia orders and change in Wo Care Protocol. Any staff not attending | n. Dund | |
| | | | <u>.</u> | | mandatory in-services w be allowed to work until have attended the in-serv | they ice. | |
| | | • | | | Effective 6/14/13 the new electronic medication systis scheduled to go live. The company began | stem | |
| | • | • | | | educational training on 5, with implementation in June. The new EMR sys will eliminate paper order paper MARs. Document will be electronic. | tem | |
| | | | • | 2) | Beginning 6/4/13 the DO & Supervisor checked all resident's chart for any missed orders for the past months. There were no residents with missed order | 3 | |
| 1000 | | | | 3) | To ensure the deficient produces not recur, the DON & Supervisor will begin on 6/13/13 checking all writted orders daily for 4 weeks, the | c/or | |
| v CMS-2567(02- | 99) Previous Versions Obse | Xete Event ID: 4XKZ11 | Fi | citity (D: Th | V7201 If another at | | |

| ATEMENT (| OF DEFICIENCIES CORRECTION | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) Mi A. BUIL | ULTIPLE C DING | CONSTRUCTION | OMB NO | APPRO). 0938-0 TE SURVEY MPLETED |
|------------|-------------------------------|---|--------------------|-------------------|---|---|--|
| | | 44E200 | B. WIN | G | | | |
| AME OF PRO | OVIDER OR SUPPLIER | | ···· | | ADDRESS, CITY, STATE, ZIP CODE | 05 | /30/2013 |
| AURELBI | ROOK SANITARIUI | Vi | | 114 C | AMPUS DRIVE | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ~ | | TON, TN 37321 | · | |
| TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF | ix | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) | VIII D DE | (X5) COMPLET DATE |
| - | | | | | | | |
| 1 | | | | • | random sample month | ly for | |
| l l | | | | • | any missed orders. If | anv i | |
| 1 | | • | Ì | - | errors or omissions are | found, | • |
| . 1 | • | | 1 . | . | the responsible staff m | ember | |
| | | | ' | | will be notified within and disciplinary action | 24 hours | |
| ļi | | • | 1 | | imposed. |] | |
| į | • | | | | <u>-</u> | } | |
| # | | : | | | Beginning 6/13/13 the | | |
| ļ | | | } | ĺ | Consultant Pharmacist | will also | |
| .] | | | 1 | Į | monitor for any missed | orders | • |
| 1 | | | 1 | | or transcribing errors m and report to the DON t | onthly ba | |
| | | | Ĭ | | outcomes of the monitor | ring. | |
| | | | | 4) | Beginning 6/13/13, the l | DON | |
| Ť | - | | | | will report monitoring | ŀ | |
| 1 | • | | | 1 | outcomes quarterly to Q | API | |
| | | | - | - | Committee. The next Q | API | |
| - } | | | | - | meeting is scheduled fo 8, 2013. The Administra | r July | |
| İ | • | · | | | will report outcomes at f | he news | |
| - 1 | | | | ĺ | Governing Body meeting | , in the state of | |
| | | | | | | " | |
| | • | | | | | - <u> </u> - ' | |
| | | | | 1 | ; | 1 | |
| | | | | } | | | |
| | | | | | • | | |
| | | ŀ | | | • | İ | |
| } | - | . } | | 1 | | | |
| | | | | 1 | | . | |

| NEMEN | IT OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | T | | | MB NO | M APPRO\). 0938-0: |
|---|--|---|----------------------|-----------|--|---------|------------------------------------|
| NAJ4 CI | OF CORRECTION | IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | TIPLE CON | RUCTION | (X3) DA | Z: 0336-0. TE SURVEY MPLETED |
| | | 44E200 | B. WING | | _ | | |
| AME OF F | PROVIDER OR SUPPLIER | | - | STREET AL | DDRESS, CITY, STATE, ZIP CODE | 05 | /30/2013 |
| AUREL | BROOK SANITARIUM | | | 114 CAN | MPUS DRIVE | | |
| (X4) ID | · SUMMARY STAT | EMENT OF DEFICIENCIES | - | DAYIO | N, TN 37321 | | |
| PREFIX TAG | LEACH DEFICIENCY | MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | PREFE TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | (X5) COMPLETA DATE |
| F 314 | Continued From pag | .—. µe 5 | F 2 | | | | <u> </u> |
| | (centimeter) Width 3 | .5 cmDrainagenone" | F3 | 14) | | | |
| ļ | Medical record revie | w of the physician's orders | | | | | |
| | C Southing (millionams | 013, revealed "Vit (Vitamin)) po (by mouth) BID (twice a | | 1 | | | <u> </u> |
| day) x 2 weeks. Zinc 2 weeks. Multivitamir | | 200mg no OD (avanzidad) v | | | · | | |
| | Medical record review of the Medication Administration Record dated January, 2013, and February, 2013, revealed no documentation the Vitamin C, Zinc, or Multivitamin had been administered. | | | | | | |
|], | | | | | | | |
| | vvorksneet dated Jan (left and right) buttock | v of the Wound Assessment uary 29, 2013, revealed " isstage II#1 L-(length) width)-0.3 (centimeters) | | | | | |
| o h | confirmed the Vitamin ad not been administ lurse Practitioner. | 2013, at 8:45 a.m., with the ON), in the DON's office, C, Zinc, and Multivitamin ered as ordered by the | | F 325 | 483.25(i) MAINTAIN | | |
| 325 4 S=D U | 83.25(i) MAINTAIN N INLESS UNAVOIDAE | UTRITION STATUS | F 328 | ; NUTI | RITIONS STATUS UNLES VOIDABLE | SS | C/18/13 |
| as | ased on a resident's seessment, the facility | comprehensive y must ensure that a | | Based | on a resident's comprehensi | ive | |
| (1 st ur | alus, such as body w Ness the resident's cl | le parameters of nutritional eight and protein levels, inical condition | | that re | ment, the facility must ensuresident -1) Maintains acceptanteters of nutritional status, surely weight and protein levels, | ble | |
| (2 | emonstrates that this) Receives a therape utritional problem. | is not possible; and utic diet when there is a | | unless | the resident's clinical condi- strates that this is not possib | tion | |

| NAME OF LAUREL (X4) ID PREFIX TAG | | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | B, WING | SYREET ADDRESS, CITY, STATE, ZIP COD 114 CAMPUS DRIVE DAYTON, TN 37321 PROVIDER'S PLAN OF COR | OMB NI (K3) DI CC | M APPROV O. 0938-0 YE SURVEY MPLETED |
|---|---|---|-----------|--|-------------------|---|
| (X4) ID PREFIX TAG | SUMMARY STAT (EACH DEFICIENCY) REGULATORY OR LSO | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING IMPORMATION) | ID PREFIX | SYREET ADDRESS, CITY, STATE, ZIP COD 114 CAMPUS DRIVE DAYTON, TN 37321 PROVIDER'S PLAN OF COR | OS RECTION | |
| (X4) ID PREFIX TAG | SUMMARY STAT (EACH DEFICIENCY) REGULATORY OR LSO | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX | SYREET ADDRESS, CITY, STATE, ZIP COD 114 CAMPUS DRIVE DAYTON, TN 37321 PROVIDER'S PLAN OF COR | RECTION | /30/2013 |
| (X4) ID PREFIX TAG | SUMMARY STAT (EACH DEFICIENCY I REGULATORY OR LS) | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | PREFIX | DAYTON, TN 37321 | RECTION | .50/ZU [3 |
| PREFIX | REGULATORY OR LS | C IDENTIFYING INFORMATION) | PREFIX | PROVIDER'S PLAN OF COR | RECTION | _ |
| TAG | REGULATORY OR LS | C IDENTIFYING INFORMATION) | PREFIX | PROVIDER'S PLAN OF COR | RECTION | _ |
| F 325 | Continued From page | | | CROSS-REFERENCED TO THE A DEFICIENCY) | PPROPRIATE | CONSTE |
| | | 8 6 | F 32 | | | · |
| 1 | | | 1 | · —- | | |
| 1 | | | 1 | Resident #3 | | I |
| | This REQUIREMENT by: | is not met as evidenced | | 1) Beginning 6/2/12 and | į | |
| j. | Based on medical cod | Social decidence | | - S | đ þ | |
| | | | | continuing every day | , the DON | |
| | | | | &/or Supervisor had | one on | |
| , , | (#3) of twenty-four resi | 7004 mm 4 | | one in-services with | 7-3& 3-11 | |
| , | | | i | CNAs and feeding to documentation of me | chs on | |
| T | The findings included: | , | | until all CNAs & feed | ai intake | |
| İR | Resident #3 was admit | Manual 3- 45 - 4 | i | were in-serviced. | ung techs | • |
| | | | ľ | | | |
| | | | 1 | Beginning 6/13/13 the | charge | |
| | | rsychosis, Seizura litus, History of Nausea utaneus Feeding Tube | Ì | nuises on the day and | evening | |
| (F | EG) placement, | counters reeding Tube | ļ | smus will check | _ | |
| 100 | Adlant security of | _ | ł | documentation of each | | |
| On | set date December 1. Problem Obseits | of the resident's Care Plan | - 1, | CNAs documentation | of meal | |
| , ,,,, | ·· / • • • • • • • • • • • • • • • • • • | 101 ta áil na as - ! | | percentage and if not | į | |
| We | eight or belowApproa | 3chPraise (resident) | 1 | completed, CNA must | } | |
| | | | - 1 | complete before he/she | can go | - 1 |
| 20 | 12. revealed " Proble | er care January 27 | i | home. | | - 1 |
| | | | i | If a CNA consistently fa | ,:Ta 4- | - 1 |
| PE | G Tube for all meals a | and medications" | 1 | record the meal percent | 712 to | |
| | dical record review of | | } | than 3 times per week he | e/ che | 1 |
| 11000 | vaniulation omare 454 | DAT BEOLULE DALLA | 1 | will be reported to the D | ON for | - ! |
| 11971 | DUSCU I CAKUPIN WAININ | * 5 £645 £ 654 £ 4 ± = | | disciplinary action and r | e in- | |
| | | | 1 | serviced. | | J |
| 27. | 2013 (original data of | order) | | | 1 | 1 |
| | | | | | | - ! |
| (as | needed) give if eats le | ess than 25 % of meal" | - 1 | | | - 1 |

| TEMENT PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | LTIPLE CONSTRUCTION DING | OMB NO. 0 (X3) DATE 8 COMPL | SURVE |
|----------------------|--------------------------------------|--|--------------------|---------------------------------------|-----------------------------------|-----------------------|
| | | 44E200 | B. WING | 5 | | |
| ME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 05/30 | /201 |
| URELE | BROOK SANITARIUN | 1 | | 114 CAMPUS DRIVE | | |
| aup I | SI MALANDY OTA | | | DAYTON, TN 37321 | | |
| A) ID REFIX AG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREF TAG | | | (XS) OMPLE DATE |
| - [| | | | On 6/10/13 & 6/11/13 the | | |
| H | | | ł | Director of Nursing (DON) | } | |
| I | _ | | | conducted a mandatory in- | | |
| | • | |] | service for all licensed nurs | ing | |
| | | | | staff (RN, LPN) concerning | | |
| ` .∦ | | | ' ' | recording tube feedings on | | |
| ľ | | • | ļ | MAR and the policy on | | |
| ŀ | | | | documentation of medication | ons. | |
| | | : | | Any staff not attending | | |
| i I | | | | mandatory in-services will | not | |
| | | | | be allowed to work until the | | • |
| | | | i i | have attended the in-service | | |
| | | | [| Effective 6/14/13, the new | | |
| - 1 | | | | electronic medication system | n i | |
| | | | | purchased by facility will g | | |
| | | | | live. The company staff beg | | |
| | | | | educational training on | | |
| ŀ | | ľ | • | 5/13/13 with implementation | | |
| ĺ | | ļ | | in June. The new EMR sys | | |
| | • | : | | will not allow nurses to leave | re 1841 | |
| | | | | blanks on the MAR. It will | | |
| ľ | | | | also be easier to check for | 1 | |
| | : | | | documentation of meal percentages. | . 7, 7 | |
| | | ĺ | | Porooniages, | | |
| | | } | | } | <u></u> | |
| | • | | | | | |
| | | | | | | |
| | - | . [| | | | |
| | | 1 | | | | |
| | | | | 1 . | ļ | |

| ND PLAN OF | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | JLTIPILE CO DING | DISTRUCTION | (X3) DA | D. 0938-03 TE SURVEY MPLETED |
|--------------------------|-------------------------------------|---|--------------------|---------------------|--|---|------------------------------------|
| | | 44E200 | B. WING | G | <u> </u> | 1 | |
| | VIDER OR SUPPLIER OOK SANITARIUN | 1 | | 114 C/ | ADDRESS, CITY, STATE, ZIP CODE AMPUS DRIVE ON, TN 37321 | <u> </u> | /30/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | ıx | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | 1 D DC | (X5) COMPLETA DATE |
| | | | | 3) | Beginning 6/13/13 the I & Supervisor checked all resident's chart for a missed documentation of percentages and tube feed and medications not documented. There were residents with missed me percentages or missed to feeding or medication documentation. These checking or medication documentation. These checking the conducted daily for weeks, then randomly on monthly basis. To ensure the deficient produces not recur, the DON Supervisor will begin on 6/13/13 checking documentation daily for weeks, then a random sammonthly for any omission documentation of percentages and documentation of meals and documentation any errors or omissions are found, the responsible statementage will be notified week to facility to correct the | ny on meal eding e no eal be necks or 4 a ractice &/or nple of tage on of ns. If | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ULTIPLE CON DING | STRUCTION | OMB NO (X3) DA CO | TE SURVEY |
|--------------|---------------------------------------|---|-------------------|---------------------|---|-------------------------|-------------------------|
| | · . | 44E200 | B. WIN | G | | | |
| | OVIDER OR SUPPLIER ROOK SANITARIUI | A | | 114 CA | DDRESS, CITY, STATE, ZIP CODE MPUS DRIVE | 1 05 | /30/2013 |
| X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | | | N, TN 37321 | · | |
| REFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREF TAG | TIX | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | NU D OF | (X5) COMPLET DATE |
| - | | | | | | | |
| | | | | • | documentation. Conti | nued | |
| | · , | | | | deficient practice will disciplined by the DOI | N. | |
| | | | : | . | Beginning 6/13/13 the | | |
| <u> </u> | | | | | Consultant Pharmacist monitor for any missec | will also | |
| | • | | | | documentation of med | ications | |
| | | • | | | monthly and report to t the outcomes of the monitoring. | he DON | r |
| | | | 1 | 4) | Beginning 6/13/13, the will report monitoring | } | • |
| | | | | | outcomes quarterly to (Committee. The next (| DAPI | |
| | | | | | meeting is scheduled f 8, 2013. The Administ | rator | |
| | | | | | will report outcomes at Governing Body meeting | the next | |
| | , | | | | Covering Dody Meetil | 1g. | #** |
| | | : | | | ** *** **** |] | |
| | | ; | | | - · | · . | |
| | | ļ | | · s | • | | |
| | | | | | ٠., | } | |
| | | | | | | 1 | |
| - | • | ` <u>'</u> | | | | | |

| | ERS FOR MEDICARI | DCU547PM13501 HAND HUMAN SERVICES & MEDICAID SERVICES | | | PRINTE | P 11/2 D: 06/03/2 MAPPROV |
|---|--|---|-------------|---|---------------------------------|---------------------------------|
| WD PLAN | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MQ | ILTIPLE CONSTRUCTION | OMB NO | <u>0. 0938-0</u> |
| | | NON HUMBER | A BUIL | DING | (X3) DA | TE SURVEY |
| | | 44E200 | B. WING | | " | MITTERED |
| | PROVIDER OR SUPPLIER | | 25. 40 1467 | | 0.5 | <u>/30/</u> 2013 |
| LAURE | LBROOK SANITARIUM | I | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE | | 15012013 |
| (X4) ID | SIMILARY CTA | | | DAYTON, TN 37321 | | |
| PREFIX | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | 1D | PROVIDER'S ELAN OF ACT | | |
| | WESOCKIDE OF E | C DENTIFYING INFORMATION) | PREFI | CROSS-REFERENCED TO THE ACT | iction ICULD BE PROPRIATE | COMPLETE DATE |
| F 325 | Continued From pag | | _ | DEFICIENCY | | |
| 7.2 | ooveringen From bag | je / | F 3 | 25 | | |
| j | Medical record review | w of the resident's Daily Meal | | | } | i |
| ļ | | | ļ | 1 | | |
| | revealed fifty of sixty documentation of the | | | | 1 | |
| | Medical record roving | 4 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 | • | | | |
| | | | | | | |
| | and April 2013, revea | led only seventeen days the | | 1 | 1 | |
| li li | prough the table star | iss only seventeen days the sumented as administered ilcal record review of a | | 5 | 1 | |
| | | | | 1 | | |
| | | | | İ | } | |
| Į, | vausea and vomiting | occuring more often" | | | | |
| lo | bservation of the ear | | | | | |
| 8 | :53 a.m., in the reside | ont room, with Certified | | 1 | - 1 | |
| re | sident's current welg | ht was 139 pounds. | | | | |
| Į į į | iterview with the Phys | ician and the Director of | | | 1 | |
| Į N | ursing (DON) in the s | ocial services office, on | | | | |
| PI | Tysician was awass at | a.m., revealed the | | | 1 | |
| ar | d the resident was st | the resident's weight loss ill within ideal body weight | | | | - 1 |
| | | | | | Ì | - 1 |
| , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | CITICAL AND IN THE SUPPLY | NM NA | - 1 | | | i |
| | | risistant nausea and idder concerns had been | 1 | | | - [|
| rul | ed out as a possible (| Zause. | ŀ | | 1 | 1 |
| 1 | | | ! | | 1 | - 1 |
| inte | e teelbam bus weive | cord review on May 30, | ļ | | j | - 1 |
| | | |] | | } | - 1 |
| 1,44 | HILF HUNER IN CHINSTON | NGU BRIO BURGES AND A CO | | | | 1 |
| 1.00 | ident's meal intake ar 9 feeding, | of administration of the | - 1 | | 1 | 1 |
| 72 AR3 | .35(I)(3) DISPOSE G | ARBAGE & REFUSE | E 070 | | | j |
| | | THE WATER OF THE | F 372 | | l | - 1 |

| TEMENT | OF DEFICIENCIES | (X1) PROVIDER | SUPPLIERICLIA | (Ve) 4 ** | | | OMB NO | APPRO 0. 0938-0 |
|--------------|------------------------------------|------------------|---------------|-------------|-------------------|---|---------|----------------------|
| PLAN O | FCORRECTION | IDENTIFICA | TION NUMBER: | A. BUIL | JLTIPLE (DING | CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 44 | E200 | B. WIN | S | | | |
| AME OF PR | OVIDER OR SUPPLIER | | 4 | <u></u> - | STREE | TADDRESS, CITY, STATE, ZIP CODE | 05 | /30/2013 |
| AURELB | ROOK SANITARIUI | М | | |] 114 | CAMPUS DRIVE | | |
| (X4) ID | SUMMARYST | ATEMENT OF DEFI | CIENCIES | | DAY | TON, TN 37321 | | |
| RÉFIX TAG | (EACH DEFICIENC REGULATORY OR I | Y MILST RE PRECE | DED BY ELLI | PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | | COMPLETA DATE |
| - [| | | | | | | | |
| | | | | | • | F 372 483.35(1)(3) DISPOSE GARBAGE & REFUSE PROPERLY | į | 6/11/1 |
| | | | | : | - | The facility must dispose of gand refuse properly. | arbage | |
| | | • | · | | 1) | deficient practice on | [| |
| | | | | ī | | 5/28/13, the Dietary Mana immediately arranged the in the dumpsters so lid wo close. | trash | |
| | | | | | | 0.030. | | |
| ĺ | - | | | | | On 6/4/13 the Dietary Mar | ager | |
| ł | | | - | | | conducted one on one in- | | |
| - { | | | | | | service with the staff takin | g | |
| - | • | | | | | trash out on 5/28/13 on the proper method of disposal | of | |
| | • | - | | | - | trash. | 01 | |
| | • | | 7 | | | On 6/10/13 & 6/11/13 the | | |
| | | | | | ļ | Dietary Manager conducted | da 📗 | |
| | | | -7 | | | mandatory in- service for a | 11 | |
| | • | | *** | | | Dietary staff concerning proper disposal of trash and | .] | |
| | | | | |] | closer of dumpster lid at | 1 | |
| | | | | | | all times. | | |
| | | | 1 | , | | Any staff not attending | } | |
| | | | . [| |] | mandatory in-services will i | not | |
| 1 | | | Î | | | be allowed to work until the | ev (| |
| | | | | | | have attended the in-service | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | LTIPLE CO | ANSTRUCTION . I, | MB NO. 0938-03 (X3) DATE SURVEY COMPLETED | |
|---------|---|---|---------------------|-----------|--|---|--|
| | | 44E200 | B. WING | s | | | |
| | ROVIDER OR SUPPLIER BROOK SANITARIUM | 1 | | 114 C/ | ADDRESS, CITY, STATE, ZIP CODE | 05/30/2013 DE | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | 7 | DATI | ON, TN 37321 | | |
| TAG | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E COMPLETIO NTE DATE | |
| - | | | | (2) | Beginning 6/13/13 the Diet | | |
| | | | 1 | -7-7 | Manager created a check lis | ary | |
| | | • | ľ | ĺ | for a daily check of the | št į | |
| | | | 1 | } | dumpster to ensure the lid is | _ | |
| · • | | | <u>.</u> | . | closed. This assignment wil | 5 | |
| • • | | | <u> </u> | | be given to one dietary staff | 500 | |
| | | • | j | 1 | a weekly basis. Any improp | er | |
| l | | | | | disposal will be corrected | ľ | |
| | | • | | 1 | immediately and reported to | | |
| ļ | | • | | ŀ | the Dietary Manager of | | |
| ľ | | | | - | findings. | | |
| | | | , | 3) | To ensure the deficient pract | | |
| | | Î | • | | does not recur, the Dietary | ice i | |
| ľ | | | | 1 | Manager will begin on 6/13/1 | 13 | |
| ļ | | ٠, | | 1. | checking documentation dails | , , | |
| | | - 1 | | j | 10r 4 weeks. If any errors or | '] | |
| } | | • 1 | | Į. | omissions are found or | | |
| ļ | • | j | | į | reported, the responsible staff | f | |
| į | | Ç. | • | į. | member will be re-in-serviced | 1 | |
| ŀ | , | : A. Vey. | | ļ | and if continued deficient | | |
| | | | | | practice will be disciplined by the Dietary Manager. | <i>,</i> ' | |
| | | | | 4) | Beginning 6/13/13, the Dietar | | |
| | · | | | | Manager will report monitoring | y Nor | |
| | • | | | | outcomes quarterly to OAPI | '5 | |
| | | * | |] | Committee. The next OAPI | [| |
| 1 | | | | | meeting is scheduled for July | | |
| ĺ | | į. | ~ | | 8, 2013. The Administrator | l l | |
| } | • | - <u>k</u> | | | will report outcomes at the nex | st i | |
| ļ | | Î | | | Governing Body meeting. | | |
| | 99) Previous Versions Obse | | | ľ | • | 1 1 | |

| STATEME | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TIPLE CONSTRUCTION NG | OMB NO (X3) DA | M APPROD. 0938-0 ATE SURVEY MPLETED |
|---------------|---|---|---------------|--|--|---|
| | | 44E200 | B. WING | | | WIF CE TED |
| NAME OF | PROVIDER OR SUPPLIER | | | | 05 | <mark>/30/2</mark> 013 |
| LAURE | LBROOK SANITARIUA | 1 | ľ | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | T ID | The state of the s | | |
| PREFIX TAG | REGULATORY OR L | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | ^18 b bc | (X5) COMPLE DATE |
| F 372 SS=C | | ge 8 | F 37 | 2 | | |
| | property. | pose of garbage and refuse | | F 441 483.65 INFECTION CONTROL PREVENT SP LINENS | READ, | Gluli |
| F 441 SS=D | Based on observation failed to ensure garbidisposed of properly. The findings included the findings included the findings included the facility must established the facility must established facility must established facility must established facility must established facility must established facility must established facility must established facility must established facility must established facility must established facility must established facility; 2) Decides what prochould be applied to a facility of the facility; | d: rview with the Dietary 2013, at 10:58 a.m., le dumpsters with trash interview with the dietary he dumpster lids are to be CONTROL, PREVENT blish and maintain an gram designed to provide a infortable environment and evelopment and transmission on. rogram blish an Infection Control it - it - it - it - it - it - it - it - | F 441 | The facility must establish an maintain an Infection Control designed to provide a safe, sa and comfortable environment help prevent the development transmission of disease and in Resident #28 1) Upon being made awa deficient practice on | Program nitary and to and affection re of the ge nged the nidifier the ON) in- taff erning and ange. | |

| VIEWEN | IT OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | /X21 1.41 | # 74c | I CONSTRUCTION | OMB NO | 1 APPRO\ 0. 0938-0: |
|--------------|--|---|-------------------|-------|--|---|--------------------------|
| CPLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | LE CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
| | | 44E200 | B. WING | 3 | | | |
| ME OF I | PROVIDER OR SUPPLIER | | <u></u> | _ | | 05/ | 30/2013 |
| AUREL | BROOK SANITARIUM | | ı | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE | | |
| (X4) ID | SUMMARYSTA | TEMENT OF DEFICIENCIES | , | L | DAYTON, TN 37321 | | |
| REFIX TAG | I (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D DE | (X5) COMPLETA DATE |
| F 441 | Continued From page | de 9 | | | be allowed to work until | fhev | |
| | , | | F 4 | 141 | have attended the in-serv | rice | |
| - { | (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to | | | ĺ | On 6/9/13 the DON revi | nod | |
| | | | | | the Administration of | seu | |
| 1 | | | • | | Medication to include the | _ | 1 |
| ľ | prevent the spread of isolate the resident. | of infection, the facility must | | ŀ | evaluation of Oxygen tul | | |
| ĺ | (2) The facility must | prohibit employees with a | | | and humifier on a schedu | ung | |
| | communicable disea | Promott employees With a | | - [| basis and to be recorded | itea | |
| - 1 | communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted | | | | MAR. The DON will in- | on the | |
| | | | | | Service this was in | • | |
| i i | | | | Į | service this revision of th | | |
| | | | | Ì | Administration of Medica | ation [| |
|]; | professional practice | cated by accepted | | - { | policy at the mandatory | } | • |
| . [' | professional practice | • | | | meeting on 6/10/13 & 6/1 | 1/13. | |
| | (c) Linens | ļ | | | 2) 13 | - | |
| | Personnel must hand | lle, store, process and | | ĺ | Beginning 6/4/13 the DO | N | |
| 1 | ransport linens so as | to prevent the spread of | | , | &/or Supervisor checked | - 1 | |
| | nfection. | | | | all residents who were rec | eiving | |
| - } | | | | | Oxygen for any needed 02 | 2 | |
| | | ľ | | • | tubing &/or humifier char | iges | |
| 1 | This REQUIREMENT | is not met as evidenced | | | to ensure residents had ele | ean | |
| ļū | y: | | | • | equipment. | | |
| اِ | Based on observation | n, medical record review, | | : | | /a | |
| 1 15 | acidly policy review, a | Ind interview the facility | | | | 1997 - 1 1997 - 1 2 - 1997 - 1 | |
| 18 | alled to maintain the | DXVGen fuhing and | | . 3 |) To ensure the deficient pra | | |
| '' | numer bottle in a s | anitary manner for one | | • | does not recur, the DON & | dor II | |
| '` | saldotit, #20, Ut (Well) | y- four residents reviewed. | | • | Supervisor will begin on | GOI : | |
| ⊤ | he findings included: | | | | 6/13/13 checking | 7.7 | |
| | • | | | | documentation on MAR a | nd | |
| R | esident #28 was adn | nitted to the facility on | | | nurses notes for changes in | | |
| Jā | anuary 30, 2013, with | diagnoses of Altered | | | oxygen tubing or humifier | 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | |
| IVI P | ientai Status, Diabete enal Failure, and Ane | es Mellitus, Hypertension, | | | weekly basis for 8 weeks, | on a | |
| '`` | violi rallute, alfu Ant | inia. | | | a random monthly actual | ruen C | |
| o | bservation on May 28 | 3, 2013, at 10:45 a.m., in | | | a random monthly sample any oxygen tubing not cha | ior | |
| | Zina Zina Zina Zina | 4 -4 10, at 10.45 a.m., [f] | | 1 | any oxygen tubing not cha- | nged | |

| STATEMENT ************************************ | OF DEFICIENCIES F CORRECTION | (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION 10 | B NO. 0938-03 (3) DATE SURVEY COMPLETED |
|---|---------------------------------------|--|-----------------------------|--|---|
| | | 44E200 | B. WING | | |
| | ROVIDER OR SUPPLIER ROOK SANITARIU | | 11 | EET ADDRESS, CITY, STATE, ZIP CODE 4 CAMPUS DRIVE | 05/30/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | AYTON, TN 37321 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (XS) COMPLETIO |
| | | | 4 | when needed. If any errors omissions are found, the responsible staff member will be notified within 24 hours a staff member will be required to report to DON why change were not done. Continued deficient practice will be disciplined by the DON. Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting. | ll and d es |

| DEP. CEN | ARTMENT OF HEALTH TERS FOR MEDICARE | AND HUMAN SERVICES & MEDICAID SERVICES | | F | RINTEC FORM |): 06/03/20 MAPPROVE | 13 ≃n |
|------------------------|---|---|--------------------|--|----------------|-------------------------------------|--------------|
| STATEM | ENT OF DEFICIENCIES AN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) ML A. BUIL | ULTIPLE CONSTRUCTION LDING | (X3) DAT |). 0938-039 TE SURVEY MPLETED | 91 |
| | | 44E200 | B. WING | · | | | |
| ŀ | F PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 05/30/2013 | | ᅱ |
| LAUR | ELBROOK SANITARIUM | | | 114 CAMPUS DRIVE DAYTON, TN 37321 | | | |
| (X4) H PREFI TAG | X (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREF TAG | PROVIDER'S PLAN OF CORRECTION SHOULD FIX | | (X5) COMPLETION DATE | |
| F 502 SS=D | the resident's room, cannula tubing and I of debris, and were of Review of facility pol revealed "The 02 (does not require schon one resident. It shoiled or dirty. 02 Cachecked every 14 da Review of the Respin sheet revealed no do had been checked sill Interview with License, in the resident's room a.m., confirmed the twas not clean and wa" should have been 483.75(j)(1) ADMINIST The facility must proviservices to meet the reacility is responsible for the services. This REQUIREMENT by: Based on medical recthe facility failed to obt two residents (#32, #4 reviewed. | revealed the resident's nasal numidifier and had a build-up dated April 11, 2013 icy "USE OF OXYGEN" oxygen) cannula or mask eduled changing when used ould be changed when noulas or masks will be yet for needed changing" atory Equipment check cumentation the cannula nce April 17, 2013. ad Practical Nurse (LPN) #1 m on May 28, 2013, at 10:48 abing and humidifier bottle is dated April 11, 2013, and changed" TRATION de or obtain laboratory needs of its residents. The for the quality and timeliness is not met as evidenced ord review and interview, ain laboratory services for 3) of twenty-four residents. | | 441 | in ceds | Gliy/13 | |
| | Resident #32 was admitted to the facility on | | | | | 1 | |

| DEPAR CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | FORM APPRO |
|----------------|---|--|--------------------------|--|------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IS | (X3) DATE SURVE COMPLETED |
| · | | 44E200 | B. WING | | ł |
| | ROVIDER OR SUPPLIER BROOK SANITARIUM | | i | TREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE | 05/30/201 |
| (X4) ID | SUMMARY STAT | EMENT OF DEFICIENCIES | | DAYTON, TN 37321 | |
| PRÉFIX TAG | EACH DEFICIENCY | MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | DOC 2004 |
| - (| | | - | who failed to draw blood on | <u> </u> |
| 1 | | | 1 | 5/10/13 for TSH on Resident | # |
| N. | | | | 32 and the nurse who wrote t | he l |
| ĺ | | • | Ì | order for Albumin on 1/19/13 | |
| | • | | | for resident # 43 but failed to | |
| | | | ' | order lab resulting in failure of | of |
| | | • | <u> </u> | lab being drawn. (Exhibit #12 | 2) |
| ľ | • | | , | On 6/3/13, the DON reviewed | |
| ŀ | | • | | the 24 hrs chart check policy | • |
| ŀ | | | | and will continue with the 24 | ļ |
| · | | | | hour chart check | , |
| j. | | | it l | implemented 3/19/13 for | } |
| | | | ' | checking all charts for written | , |
| | | · | | orders in the past 24 hours. |] |
| | | ļ | } | This policy and process will be | e [|
| | | | | re-reviewed with the nursing | j |
| | | | | staff (RN and LPN) on 6/10/13 & 6/11/13 by the DON. | 3 |
| | | | | On 6/3/13, the DON reviewed | |
| | * | | 1 | & decided to continue the | ļ |
| | | <u>:</u> | | process for a second nurse | ĺ |
| 1. | | | | check on written physician | } |
| | • | } | 1 | orders that was implemented | |
| | | | ļ | 3/19/13. The second nurse will | l [|
| | | | ſ | check the first nurse's work | ĺ |
| | | · | } | on the written order to ensure | f |
| İ | • | | | order was written accurately | 1 |
| - | | - | | and transcribed correctly to | 1 |
| | | - 1 | ĺ | MAR, requisition completed, fax to pharmacy, given to | ł |
| ļ | | Ì | - 1 | phlebotomist, etc. This | 1 |
| | -99) Previous Versions Obso | | 1 | I THIS | 1 |

| ATEMENT D PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | OMB NO. 0938- (X3) DATE SURVE COMPLETED | | |
|------------------------|---|---|---------------------|--|--------------------------------|--|
| | | 44E200 | B. WiNG | B. WING | | |
| | ROVIDER OR SUPPLIER BROOK SANITARIUN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE | <u> 05/30/201</u> ; | |
| | | | | DAYTON, TN 37321 | | |
| X4) ID REFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | " (| 1111 DE ~~~~~~~ | |
| 700 | | | | policy and process will be reviewed with the nursing (RN and LPN) on 6/10/13 6/11/13 by the DON. On 6/7/13 the DON review | staff & | |
| | | • | | the revised Lab monitoring to include the returned lab results on 3/19/13 and decreased to continue using the lab loassist in monitoring ordered test. | g log ided og to | |
| | | | | On 6/7/13 the DON decide continue with the following process put in place on 3/1 to add ordered lab to the M so nurse must initial the square on date of draw which serves as a reminder to check for lives of the square of the s | g 9/13 (AR pare es | |
| | | | | On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory inservice for all nursing staff (RN, LPN, CNA) concerning transcribing physician order 24 hour Chart Check, Secondurse check on physician. | ng rs , nd | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) ML A. BUIL | ILTIPLE C | OMB NO. 0938-0: (X3) DATE SURVEY COMPLETED | | | |
|-------------------------|---|---|--------------------|---------------------------------------|--|-------------------------|--------------------------|--|
| | | 44E200 | B. WING | | | - 1 | | |
| | ROVIDER OR SUPPLIER BROOK SANITARIUM | | <u></u> | STREET ADDRESS, CITY, STATE, ZIP CODE | | | /30/2013 | |
| | | | | | TON, TN 37321 | | | |
| (X4) ID REFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DE | (X5) COMPLETI DATE | |
| - | ÷ | | | | ensure the lab was drawn results returned. | and | | |
| | | • | <u>:</u> | | Any staff not attending mandatory in-services will be allowed to work until the have attended the in-services. | nev | | |
| | | | | | Effective 6/14/13, the new electronic medication system purchased by facility will plive. The company staff be educational training on 5/1 with implementation in June. The new EMR system | em go gan 3/13 | | |
| | | | · | | will eliminate paper orders paper MARs. Documentat will be electronic. Monitor lab orders can be done electronic on a weekly or d basis. | ion ing | | |
| | | | | 2) | Beginning 6/4/13 the DON & Supervisor checked all resident's chart for any missed lab orders for the pamonths. There were no residents with missed orders | st 3 | | |
| | | | | 3) | To ensure the deficient practices not recur, the DON &/ Supervisor will begin on 6/13/13 checking all written | or | | |

| ATEMENT D PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED |
|---|---------------------------------|---|--------------------|--|
| | | 44E200 | B. WIN | ING |
| AME OF PROVIDER OR SUPPLIER AURELBROOK SANITARIUM | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 |
| X4) ID REFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE |
| | | | | orders daily for 4 weeks, then a random sample monthly for any missed orders of any kind. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and disciplinary action imposed. |
| | | | : | 4) Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting. |
| | - | | | |
| | | | | |

| DEPA CENT | RTMENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | FOR | D: 06/03/2013 M APPROVED |
|--------------------------|---|---|--------------------|--|--------------------|--|
| STATEME | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ILTIPLE CONSTRUCTION DING | (X3) D, | O. 0938-0391 ATE SURVEY OMPLETED |
| | | 44E200 | B. WING | S | | Elaniania |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 | . (0: | 5/30/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | III D BE | (X5) COMPLETION DATE |
| | Hypothyroidism, Cell Heart Failure, and A Medical record revise order dated April 10, (laboratory test for T this month" Medical record revise the TSH had been of Interview on May 29 Director of Nursing, confirmed the TSH had been of Interview on May 30, confirmed the TSH had been of Interview on May 30, Hypertension. The reson February 7, 2013, with Dementia, Diabetes, Hypertension. The reson February 7, 2013, Medical record revised dated January 19, 20, Albumin level and if I protein powder 2 scould be a source of Nursing (I confirmed the Albumin obtained as ordered in 483.75(I)(1) RES | 2, with diagnoses including liulitis, Diabetes, Congestive trial Fibrillation. Ew of a Nurse Practitioner's 2013, revealed "TSH hyroid Stimulating Hormone) Ew revealed no documentation completed. 2013, at 2:50 p.m., with the in the Social Services office, had not been completed. Idmitted to the facility on hidiagnoses including Failure To Thrive-Adult, and esident expired at the facility of the physician's orders 213, revealed " Check ow (less than) (3.5), start tops daily x 2 weeks | F 51 | F 514 483.75(I)(1) RESIDEN' COMPLETE/ACCURATE/A SIBLE The facility must maintain clin records on each resident in acc with accepted professional star | ical ordance dards | 61.4/13 |
| | | | | organized. | - | |

| DEPAR CENTE | RTMENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | £ | RINTE(FORM |): 06/03/201 APPROVE |
|---------------------------------------|--|--|---------------------|--|--|-------------------------------------|-------------------------------------|
| ISTATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | |). 0938-039 TE SURVEY MPLETED |
| · · · · · · · · · · · · · · · · · · · | | 44E200 | B. WING |) | | | |
| NAME OF | PROVIDER OR SUPPLIER | | · | | DEET ADDRESS COMMISSION OF THE PROPERTY OF THE | 05 | /30/2013 |
| LAUREL | BROOK SANITARIUM | | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321 | | |
| (X4) ID PREFIX TAG | I (EACH DEFICIENCY | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.) | P.F. | (X5) COMPLETION DATE |
| | resident in accordant standards and practical accurately document systematically organ. The clinical record minformation to identify resident's assessment services provided; the preadmission screen and progress notes. This REQUIREMENT by: Based on medical reand interview the facing medical record was a meal intake and admit one resident (#3) of two reviewed. The findings included: Resident #3 was admit according to the service of the | intain clinical records on each ce with accepted professional ces that are complete; ted; readily accessible; and ized. The resident are cord of the resident; a record of the results of any ing conducted by the State; The resident as evidenced cord review, observation, lity failed to ensure the courate for the monitoring of nistration of tube feeding for venty-four residents. | F 5 | | Resident #3 1) Beginning 6/3/13 and continuing every day, the &/or Supervisor had one of one in-services with 7-3& CNAs and feeding techs of documentation of meal into until all CNAs & feeding to were in-serviced. Beginning 6/13/13 the character in the day and every shifts will check documentation of each CNAs documentation of each CNAs documentation of mean percentage and if not completed, CNA must complete before he/she care home. If a CNA consistently fails the record the meal percentage in than 3 times per week he/she will be reported to the DON | DON on 3-11 n ake echs rge ning eal | LAIE |
| S C a () | October 22, 2010, with Severe Schizophrenia Disorder, Diabetes Me and Vomiting, and Per PEG) placement. | of the resident's Care Plan | | | disciplinary action and re inserviced. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory inservice for all licensed nursing. | ng | |
| w e | Problem ObesityG eight or belowAppr | ioalwill remain at current oachPraise (resident) | | | staff (RN, LPN) concerning recording tube feedings on t MAR and the policy on documentation of medicatio (Exhibit # 11 | ns. | |

| DEPAR | RTMENT OF HEALTH | AND HUMAN SERVICES MEDICAID SERVICES | | | PRI | INTED | : 06/03/20 I APPROVE | 113 |
|---------------|---|--|-------------|-------|--|------------|----------------------------|-----|
| STATEME | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | 00000 | | | B NO | . 0938-03 | 91 |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | | | X3) DAT | E SURVEY | |
| | | 44E200 | B. WIN | 3 | | 0- | 201001- | |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | STR | EET ADDRESS, CITY, STATE, ZIP CODE | <u>U5/</u> | 30/2013 | _ |
| LAURE | BROOK SANITARIUM | • | | 11 | 14 CAMPUS DRIVE | | | |
| (X4) (D | SUMMARY STA | TEMENT OF DEFICIENCIES | | 1 D | AYTON, TN 37321 | | | |
| PRÉFIX TAG | / (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E TE | (X5) COMPLETION DATE | × |
| F 514 | Language Company | | F | 514 | Any staff not attending | | <u> </u> | 1 |
| | 2012, revealed "Pi | roblemGastrostomy Tube: | } | | mandatory in-services will no | | | |
| | Resident refuses PC |) (by mouth) intake, may use | | - 1 | be allowed to work until they | ot] | | 1 |
| | FEG Tube for all me | eals and medications" | | Į | have attended the in-service. | ′ I | | - |
| | Medical record revie | w of the Physician | | | navo attended the m-service. | | | |
| | Recapitulation order | s dated May 1, 2013 | | | Effective 6/14/13 the new | | | |
| | i revealed resident we | eights March 2013, 162 LBS/ i | | | | Ì | | 1 |
| | (pounds), April 2013, | 156 LBS. Continued review | | ĺ | electronic medication system | . | | 1 |
| | 27 2013 (original do | orders revealed "February | | - 1 | purchased by facility will go | | | |
| J | (calorie) PEG tube T | te of order)Jevity 1.5 CAL ID (three times a day) PRN | | | live. The company staff | | | 1 |
| | (as needed) give if ea | ats less than 25 % of meal" | | | began educational training on 5/13/13 with | | | |
| .] | Medical record review | v of the resident's Dally Meal | | - 1 | implementation in June. The | - 1 | | 1 |
| I | intake Report for Mai | ICh 2013 and Anril 2013 | | | new EMR system will not | - | | |
| 1 | revealed titty of sixty | days with incomplete | | | allow nurses to leave blanks | | | |
| | documentation of the | resident's intake. | | | on the MAR. It will also | | | 1 |
| | Modical research and and | | | | be easier to check for | | | |
| | Medical record review Medication Administra | v of the resident's ation Record for March 2013 | | - [| documentation of meal | | | 1 |
| | and April 2013, revea | led only seventeen days the | | -] . | percentages. | | | t |
| i · | Jevity 1.5 cal was doo | cumented as administered | | | F-1-0-magos. | | | ł |
| | inrough the tube. Med | dical record review of a | | - | 2) Beginning 6/13/13 the DON | _ | | |
| ſ | Dietary assessmoet d | lated May 22 2013 | | | & Supervisor checked | ١ ١ | | |
| | revealed "Resident" Navoca and versiting | s eatin (eating) varies. | | | all resident's at an C | ı | | ı |
| [] | vausea and vomiling | occuring more often" | | 1 | all resident's chart for any | | i | l |
| - 1 | Interview and medical | record review on May 30, | | Į | missed documentation on m | eai | | |
| 17 | 2013, at 1:15 p.m., wi | th the DON confirmed the | | ŀ | percentages and tube feeding | g | | |
| ון | acility failed to consis | tently monitor/document the | | | and medications not | | | |
| ין | 'esident's meal intake | and administration of the | | | documented. There were no | , | | |
| [1 | ube feeding. | | | | residents with missed meal | | | |
| - | | . " | • | | percentages or missed tube | | | |
| | • | | | | feeding or medication | | | İ |
| † | | | | | documentation. These checks | s | | |
| ĺ | | | | | will be conducted daily for 4 | . | ĺ | |
| | | · i | | } | weeks, then randomly on a | | l | ı |
| | | | | | monthly basis. | | ļ | |

| PTATEMENT | OF DÉFICIENCIES F CORRECTION | E & MEDICAID SERVICES (X1) PROVIDERSUPPLIER/CLIA (DENTIFICATION NUMBER: | (X2) MI A. BUIL | JUTIPLE C | CONSTRUCTION | MB NO | APPROV . 0938-03 E SURVEY |
|--------------------------|--|--|--------------------|-----------|--|---------------|---------------------------------|
| | · | 44E200 | B. WING | | | | |
| | ROVIDER OR SUPPLIER ROOK SANITARIUI | | | STREET | TADDRESS, CITY, STATE, ZIP CODE CAMPUS DRIVE | 05/ | 30/2013 |
| 040.55 | CI M de Core | | ·—- | | TON, TN 37321 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | (XIS) COMPLETIO DATE |
| - 1 | | | : | 3) | does not recur, the DON & Supervisor will begin on 6/13/13 checking documentation daily for 4 weeks, then a random samp monthly for any omission of | z/or ple | |
| | | | | | documentation of percenta of meals and documentation tube feeding & medications any errors or omissions are found, the responsible staff member will be notified with 24 hours and required to retain to facility to correct the | n of s. If | |
| | • | To the second se | | | documentation. Continued deficient practice will be disciplined by the DON. Beginning 6/13/13 the Consultant Pharmacist will a monitor for any missed documentation of medication monthly and report to the DO the outcomes of the monitoring. | ns | : |
| | | | , | 4) | Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator | y | |
| | 99) Previous Versions Obs | | | | will report outcomes at the ne Governing Body meeting. | xt | ĺ |